Finally, we would like to remind you to submit the renewal package for this waiver to the CMS Central and Regional Offices at least 90 days prior to the expiration of the waiver on June 30, 2017.

We want to extend our sincere appreciation to the Office of Developmental Program staff who assisted in the process and provided information for this review. If you have any questions, please contact Talbatha Myatt at (215) 861-4259.

Sincerely,

Francis T. Mccullough -S

Digitally signed by Francis T. Mccullough -S
Date: 2016.06.23 09:53:58 -04'00'

Francis McCullough
Associate Regional Administrator

Enclosure

cc: Nancy Thaler, ODP (electronic copy)
Julie Mochon, ODP (electronic copy)
Daphne Hicks, CMCS (electronic copy)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region III

FINAL QUALITY REVIEW REPORT

Home and Community-Based Services Waiver Review
Commonwealth of Pennsylvania Consolidated Waiver
Control # 0147
June *23*, 2016

Home and Community-Based Services
Waiver Review Report

Executive Summary:

The Commonwealth of Pennsylvania's Consolidated Home and Community-Based Services Waiver for individuals with intellectual disabilities provides home and community-based services (HCBS) targeted to individuals with intellectual disabilities aged three and older who require the level of care provided by an intermediate care facility (ICF) for the intellectually disabled. The latest CMS 372 Report, for the waiver year ending June 30, 2013, indicated that the Waiver served 16,647 individuals at an average annual per capita cost of $99,156.

The Centers for Medicare & Medicaid Services (CMS) approved the Consolidated Waiver for renewal of a five-year term effective July 1, 2012. This report contains a quality review of the first three years of the renewal period, from July 2012 through June 2015. These three years coincide with State Fiscal Years (SFY – July 1 to June 30), and data are presented by SFY throughout the report. The Department of Human Services (Department), as the State Medicaid agency, retains authority over the administration and implementation of the Consolidated Waiver. The Office of Developmental Programs (ODP), as part of the State Medicaid Agency, is responsible for the development and distribution of policies, procedures, and rules related to Waiver operations. An Administrative Entity (AE) is a County Mental Health/Intellectual Disability (MH/ID) Program or a non-governmental entity with a signed agreement with ODP to perform operational and administrative functions delegated by ODP related to the approved Consolidated Waiver. The AE Operating Agreement establishes the roles and responsibilities of AEs with respect to functions delegated to them for program administration.

The Centers for Medicare & Medicaid Services (CMS) conducted the current review of the waiver program in accordance to 42 CFR 441.302 and instructions in the May 28, 2004 (and February 6, 2007 update) Interim Procedural Guidance. We requested the Commonwealth of Pennsylvania to provide evidence to CMS to substantiate that the waiver is being administered in accordance with the terms of the approved Section 1915(c) waiver and that the specified assurances are met. The review was completed via a desk review of the materials submitted and ongoing communication with the ODP.

The CMS completed the review of information provided by the Commonwealth of Pennsylvania Office of Developmental Programs (ODP). The evidence submitted demonstrates that the Commonwealth of Pennsylvania substantially meets the assurances to administer the waiver.

The current waiver expires on June 30, 2017. The renewal for the Consolidated Waiver is due to CMS by April 1, 2017.

The report findings for each assurance are as follows:

I.State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The state substantially meets the assurance.

II.Service Plans are Responsive to Waiver Participant Needs

The state substantially meets the assurance.

III.Qualified Providers Serve Waiver Participants

The state substantially meets the assurance.

IV. Health and Welfare of Waiver Participants

The state substantially meets the assurance.

V.State Medicaid Agency Retains Administrative Authority over the Waiver Program

The state substantially meets the assurance.

VI.State Provides Financial Accountability for the Waiver

The state substantially meets the assurance.

Introduction:

Pursuant to §1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a state to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve state HCBS waiver programs.

CMS must assess each home and community based waiver program in order to determine that state assurances are met. This assessment also serves to inform CMS in its review of the state's request to renew the waiver.

State Waiver Name: Consolidated Waiver

Operating Agency: Office of Developmental Programs (ODP)

State Waiver Contact: Julie Mochon, MSW, Policy Supervisor
Department of Human Services (717)783-5771

Target Population: Individuals with Intellectual Disabilities

Level of Care: Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)

Number of Waiver Participants: 16,647 reported for waiver year ending June 30, 2013

Average Annual Per Capita Costs: $99,156 reported for waiver year ending June 30, 2013

Effective Dates of Waiver: July 1, 2012-June 30, 2017

Approved Waiver Services: The waiver, authorized under the provisions of 1915(c) of the Social Security Act, provides the following home and community-based services: Education Support Services; Home and Community Habilitation (Unlicensed); Homemaker/Chore, Licensed Day Habilitation, Prevocational Services, Residential Habilitation, Respite, Supported Employment - Job Finding and Job Support, Supports Coordination, Nursing, Therapy Services, Supports Broker Services, Assistive Technology, Behavioral Support, Companion, Home Accessibility Adaptations, Specialized Supplies, Transitional Work Services, Transportation, and Vehicle Accessibility Adaptations.

CMS Contact: Talbatha Myatt, MHSA, MPA
Health Insurance Specialist; 215-861-4259

Qualified Providers Subassurance C - The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

Table 3.7 Performance Measure QP.a.i.c.1.

Performance Measure: Number and percent of licensed providers that meet training requirements in accordance with state requirements in the approved waiver. (Data Source: Licensing Database)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of licensed providers that meet training requirements in accordance with state requirements in the approved waiver.* ***Denominator =*** *All licensed providers.*	N	812	269	183
	D	854	321	268
	% (N/D)	95%	84%	68%
Licensed providers who did not meet state requirements but complete trainings late and prior to the licensing inspection		N/A	N/A	41
Within 30 days		0	0	8
Within 31 – 60 days		0	0	14
Within 61 – 90 days		0	0	9
In greater than 90 days		0	0	10
Number compliant before remediation		812	269	224
% compliant before remediation		95%	84%	84%
REMEDIATION DATA				
Noncompliant requiring		42	52	44
Located documentation of training		31	27	0
Training provided staff or individual as required		0	0	17
Provider implemented system to ensure training is received timely in the future		11	25	27
Remediated within 30 days		19	39	12
Remediated within 31-60 days		12	10	13
Remediated within 61-90 days		4	3	5
Remediated >90 days		7	0	14
# Remediated		42	52	44
% Remediated		100%	100%	100%

Detail: In July 2012, the Department consolidated all licensing responsibilities under the Bureau of Human Services Licensing (BHSL). As such, oversight of this performance measure is a collaborative effort between BHSL and ODP. BHSL implemented a new enterprise-wide licensing system known as the Certification and Licensing System (CLS) during SFY 13/14. Data in 12/13 and 13/14 reflect a duplicated count of providers if multiple services were provided within a single agency.

The identification of providers in CLS is now unduplicated and according to Master Provider Identifier (MPI). As enhancements to the CLS continued, in SFY 14/15 ODP was able to determine instances where licensed providers completed the required training late but prior to the date of the licensing inspection. This information is provided as part of the discovery data.

The type of licensing database used to collect and store data changed during SFY 13-14. This change is reflected in the data. In SFY 12-13, the data source contained duplicated provider site information and lacked the functionality to drill down to a specific licensed provider agency. This duplicated count is because many licensed provider agencies possess multiple licenses as they render an array of services which require specific licenses. In SFY 13-14, a new enterprise-wide licensing system was implemented. Due to the implementation date, this allowed ODP to drill down to a specific licensed provider agency for a portion of the state fiscal year. In SFY 14-15, the new enterprise-wide licensing system was fully implemented and allowed ODP to determine the total number of unduplicated licensed provider agencies.

ODP determined the total number of licenses issued in SFY 12-13 to be 854 using the available licensing database. ODP conducted a crosswalk between licensing data and provider paid claim data that indicated the number of unduplicated licensed providers to be 314 in SFY 12-13. ODP continued this methodology for SFY 13-14 and determined the number of unduplicated licensed providers to be 319. In SFY 14-15, the enterprise-wide licensing system was fully implemented yielding a result of 268 unduplicated licensed providers at the time of the data extraction. As of February 29, 2016 the total number of unduplicated licensed provider agencies is 284. The variance between the unduplicated numbers of licensed provider agencies in the fiscal years presented is due to the frequency with which BHSL conducts licensing inspections.

Unduplicated # of Provider Agencies Licensed		
SFY 12-13	SFY 13-14	SFY 14-15
314	319	284

The Department conducts annual onsite reviews of licensed providers. The Department notes any regulatory violations, including a provider's failure to meet training requirements, and documents the findings on a Licensing Inspection Summary (LIS). The LIS is submitted to the provider who must return the document to the Department within 10 calendar days of the date of transmission from the Department. Providers must specify how the noncompliance has been corrected or will be corrected. The Department will verify that correction has been made through documentation produced by the provider showing evidence that training has occurred and the date it occurred. The provider must correct the identified violation no more than 90 days from the date the LIS was mailed to the provider.

Repeat noncompliance may affect the provider's license status. If the provider is in compliance as determined by the Department at the time a recommendation for licensure is made (i.e., following verification of compliance as described above), a regular license will be issued to the provider. If the provider is not in compliance with applicable regulations as determined by the Department, the Department may issue a provisional license or refuse to issue a license of any kind.

Agency Follow-Up and Improvement: The combination of enhancements to the consolidated LIS system, updated protocols and procedures, and communication to providers has improved the integrity of data available to inform this measure. ODP created an Informational Memo informing providers that documentation of remediation is now being reviewed and a provider could be in danger of being sanctioned if the items needed to validate that remediation occurred are not submitted to licensing staff. Sanctions may include issuing a provisional license, non-renewal or revocation of license.

Table 3.8 Performance Measure QP.a.i.c.2.

Performance Measure: Number and percent of non-licensed providers (including SCOs) that meet training requirements in accordance with state requirements in the approved waiver. (Data Source: Provider Monitoring)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) *= Number of non-licensed providers (including SCOs) that meet training requirements in accordance with state requirements in the approved waiver.*	N	166	136	129
	D	215	162	163
Denominator *= All non-licensed providers (including SCOs).*	% (N/D)	77%	84%	79%
REMEDIATION DATA				
Noncompliant		39	26	34
Staff Trained		34	22	30
Documentation developed/Missing documentation located		1	3	0
Provider voluntarily discontinued services		1	1	3
Provider services "not qualified"		1	0	0
Provider or Staff terminated		2	1	0
Remediated within 30 days		26	20	21
Remediated within 31-60 days		9	4	10
Remediated within 61-90 days		1	0	3
Remediated >90 days		3	2	0
# Remediated		39	26	28
% Remediated		100%	100%	100%

Details: Through the provider monitoring process, on a two-year cycle, AEs conduct on-site reviews of 100% of providers using the standardized monitoring tools developed by ODP. AEs review training records of the last 10 direct support staff members who were hired by each provider during the prior fiscal year. Through the supports coordination organization (SCO) annual monitoring process, ODP conducts on-site reviews of 100% of the SCOs using the standardized monitoring tools developed by ODP.

ODP reviews the training records for all SCs and SC supervisors with a waiver caseload to determine that they attended and completed all required trainings.

If the required staff training is not documented in the record, ODP or the applicable AE will notify the provider and the provider must locate missing documentation or ensure that training is provided within 30 days. The remediation for this process will occur as outlined in the

ODP-established corrective action process.

Agency Follow up and Improvement: The implementation of a Provider Applicant orientation training which will begin in January 2016 includes a component to reinforce ODP expectations for SSWs to understand each participant's ISP and support them in achieving their goals.

ODP continues with a close oversight and review of non-licensed providers to ensure adequate staff training exists at the provider level and that this training is received and completed by all newly hired staff members. This allows ODP to continue with a systematic plan for improvement. To date, efforts have focused on development and standardization of monitoring tools and enhancement of data collection and gathering to produce reports. ODP has developed a standardized termination/sanction process that is now being used as a result of previous recommendations for improvement.

ODP has communicated this standardized process via Informational Memo #062-15, issued July 31, 2015. "Enforcement Actions against Noncompliant ODP Intellectual Disability Waiver Providers" details sanctions that may be taken based on ODP's authority in the 55 Pa. Code Chapter 51 regulations. ODP has also established a sanction policy to articulate actions that may be taken in the event of repeat non-compliance. These sanctions include withholding, disallowing, suspending or recouping payment or future payment, disallowance of new service locations, services or newly-enrolled individuals.

A detailed review of monitoring results from this current provider monitoring cycle will be completed to inform additional areas that need improvement, collaboration with AEs, and training.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates the sub-assurance has been met.

IV. Health and Welfare of Waiver Participants

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The state substantially meets the assurance.

ODP uses a comprehensive electronic, internet-based reporting solution for incident management known as the Home and Community Services Information System (HCSIS). All provider entities use HCSIS to report incidents to ODP and the AEs. The ODP incident management lifecycle contains an initial notification process (known as the first section submission), investigation if warranted, final notification process (known as the final section submission), and approval process (known as the closure of the incident) as outlined in Incident Management Bulletin 6000-04-01. When an event occurs, or is alleged to have occurred, that is considered an incident per policy, the reporting entity must submit the first section of the incident report to ODP and the AE within 24

hours of discovery or recognition.

This first section of the incident report includes a description of the event, incident categorization, as well as the action taken to ensure the health and safety of the individual. Once the initial notification is submitted, ODP and the AE will review the incident first section to ensure that prompt action was taken to protect the participant's health, safety, and rights.

Certain categories of incidents are considered *critical incidents*. Critical incidents are incidents that require an investigation to be completed by an ODP certified investigator. Critical incidents are events of abuse, neglect, misuse of funds, rights violations and death. Misuse of funds and rights violations are considered exploitation. As part of the investigation, an investigator must take the first witness statement within 24 hours of being assigned an investigation. The investigator must also complete all witness interviews within 10 days of being assigned the investigation. The investigation and a final investigation determination (either confirmed or not confirmed) must be completed within 30 days. These are the ODP investigation standards (measured as part of H&W a.i.4).

An incident report is considered *finalized* when the reporting entity submits the final section of the incident report to ODP and the AE. Where appropriate, the final section of the incident will include the investigation determination as well as the corrective actions that were carried out or planned in order to mitigate and prevent the reoccurrence of the incident. All incident reports must be finalized within 30 days from the date of discovery or recognition or the incident report is not considered timely. If the reporting entity cannot finalize the incident report within 30 days due to circumstances beyond their control, the provider entity can input an extension notification. When the need for extension is submitted, the reporting entity is obligated to adhere to the extension deadline otherwise the finalization of the incident report is not considered timely.
When the reporting entity finalizes an incident report, ODP and the AE perform a review of the incident report within 30 days from the date of finalization. ODP and the AE review and make a determination regarding the investigation, corrective actions, and other pertinent information to ensure that the incident was managed effectively.

Table 5.1 Performance Measure HW.a.i.1.

Performance Measure: Number and percent of critical incidents in which prompt action (demonstrated within 24 hours) is taken to protect the participant's health, safety and rights. (Data Source: Incident Management Log) Data Pull September, 2015		SFY 12-	SFY 13-	SFY 14-15
DISCOVERY DATA				
Numerator (N) = *Number of critical incidents in which prompt action is taken to protect the participant's health, safety and rights.*	N	5,576	5,988	5,669
Denominator = *Number of critical incidents.*	D	5,565	5,988	5,669
	% (N/D)	99%	100%	100%
REMEDIATION DATA				
Noncompliant		11	0	0
Documentation completed		11	0	0
Remediated within 24 hours		11	0	0
# Remediated		11	N/A	N/A
% Remediated		100%	N/A	N/A

Details: Both ODP and AEs review critical incidents within 24 hours of entrance into HCSIS. In any incident reviewed by ODP staff when it is not clear that adequate or prompt action has been taken to protect the participant's health, safety and rights, ODP will notify the AE that day (or the next business day if the incident was reviewed during non-work hours) to ensure that appropriate action relevant to the incident type has been taken. The AE will work with the provider to ensure that action has been undertaken to protect the participant's health, safety and rights and submit notification to ODP documenting what remediation actions occurred within 24 hours. The numerator for HWa.i.1 includes a review of all incidents (as opposed to solely critical incidents) as all incident report first section submissions must outline the prompt action taken by the reporting entity to protect the health, safety, and rights of the individual.

As part of the first section review completed by ODP and AE, if it is discovered that prompt action was not taken by the reporting entity to protect the health, safety, and rights of the individual, ODP and/or the AE will communicate with the reporting entity and direct action so that remediation occurs within 24 hours of discovery by ODP or the AE. This process ensures the health and safety of the individuals served, while performing administrative authority duties specific to the management of incidents.

Participants are afforded the opportunity to file grievances about any issue or complaint with ODP or the service provider. Participants can communicate an issue or complaint to ODP via the ODP Customer Service Line or the Department of Human Services website. All complaints and grievances are logged into a database and referred to ODP regional or central office staff for resolution. In addition, provider agencies are required by policy to develop grievance procedures that explain how the agency will document, respond and resolve grievances.

Table 5.2 Performance Measure HW.a.i.2.

Performance Measure: Number and percent of AEs that review incidents within 24 hours of the report. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs who review incidents within 24 hours of the report.* ***Denominator =*** *Number of AEs.*	N	45	46	46
	D	48	48	48
	% (N/D)	94%	96%	96%
REMEDIATION DATA				
Noncompliant		3	2	2
AE reviewed incidents		3	2	2
Remediated within 48 hours		2	1	0
Remediated in greater than 72 hours		1	1	2
# Remediated		3	2	2
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP evaluates incidents filed for participants in the sample to ensure timely review by the AE. ODP documents the timeframe within which remediation action has occurred or will be completed by the AE. ODP requires the AE to develop a

Corrective Action Plan to prevent future occurrences. A single instance of non-compliance results in a non- compliance for the AE.

Table 5.3 Performance Measure HW.a.i.3.

Performance Measure: Number and percent of critical incidents finalized within the required time frame (30 days). (Data Source: HCSIS)		**SFY 12-13** As of August 2013	**SFY 13-14** As of August 2014	**SFY 14-15** As of Sept. 2015
DISCOVERY DATA				
Numerator (N) = *Number of critical incidents finalized within the required time frame.* ***Denominator =*** *All critical incidents.*	N	3,186	3,607	4,116
	D	5,281	5,898	5,446
	% (N/D)	60%	61%	76%
REMEDIATION DATA				
	Noncompliant	2,059	2,291	1,330
Provider finalized critical incident in HCSIS		2,059	2,291	1,330
Remediated within 30 days		1,390	1,562	1,034
Remediated within 31-60 days		362	355	196
Remediated within 61-90 days		157	158	51
Remediated in >90 days		186	216	15
	# Remediated	2,095	2,291	1,330
	% Remediated	100%	100%	100%

<u>**Details**</u>**:** ODP staff monitors a monthly report of critical incidents that are not finalized within 30 days and have no extension filed. This information is provided to AEs who contact providers to determine why incidents have not been finalized and why extensions have not been filed. If a provider does not finalize a critical incident within the required timeframe, the provider must finalize the incident within 5 days or file an extension request, if there are circumstances which support the need for an extension.

This measure is a subset of incidents identified in HW.a.i.1 and focuses on all critical incidents that have been finalized as of the date of the data extraction.

<u>**Agency Follow up and Improvement**</u>**:** Actions taken over time have contributed to improvement in SFY 14/15 and that improvement is expected to continue moving forward. ODP will continue to expect AEs to monitor provider performance in finalizing critical incidents using a management level report that provides 100% review of all incident submission deadlines. This report supplements the Incident Management Process Status reports used daily. A monthly "aging incidents" report will continue to be reviewed at regional risk management meetings with AEs for providers within their scope of oversight authority.
As part of the improvement strategy, ODP added questions to the provider monitoring tool and process that assess the provider's performance regarding compliance with the timely finalization of incident reports. Providers that have a low compliance percentage are now issued a corrective action plan and asked to develop an internal policy and procedure to increase their compliance.

Informational Memo #025-15 regarding the importance of timely finalization of incidents was

issued 3/27/15 to reinforce the requirements for finalizing an incident report within a 30 day timeframe or filing an extension if the 30 day timeframe cannot be met.

During SFY 14/15, ODP has worked to transition from HCSIS to an Enterprise Incident Management (EIM) system which presents an opportunity for more complete documentation of incidents and timeframes for resolution. The transition is planned for January 2016. In EIM, a dashboard report will serve as a mechanism for incident point persons and certified investigators to more easily manage tasks, in an effort to ensure timely finalization of incidents. The dashboard will provide a summary of the user's workload, and allow the user to view and manage tasks from one screen. A summary of the incidents in need of a user's attention will be among the first items displayed when a user logs-on to the system. Incidents will be grouped by submission and finalization timeframes so that users will know the items require their immediate attention. AE incident reviewers will have a dashboard that details the specific incidents in need of finalization. This tool will help AEs conduct oversight authority activities and assist them with determining which providers may be in need of technical assistance in order to comply with this requirement.

The state issued an informational memo on 3/27/15 that impacted the performance compliance by reminding stakeholders of the requirements established in policy. In addition, the Southeast region targeted technical assistance to Administrative Entities that focused on provider performance.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance with Performance Measure HW.a.i.3.

Table 5.4 Performance Measure HW.a.i.4.

Performance Measure: Number and percent of AEs that completed investigations inaccordance with ODP standards. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs that completed investigations in accordancewith ODP standards.* ***Denominator =*** *Number of AEs reviewed.*	N	18	17	30
	D	40	42	45
	% (N/D)	45%	41%	67%
REMEDIATION DATA				
	Noncompliant	22	25	15
Certified Investigator is counseled as appropriate to ODP standards		16	18	11
Certified Investigator is retrained as appropriate to ODPstandards		6	7	1
Monitoring protocol submitted and accepted		0	0	1
AE staff directed to use ALERT system in HCSIS		0	0	1
Electronic tickler developed by AE		0	0	1
Remediated within 30 days		21	20	12
Remediated within 31-60 days		1	2	3
Remediated within 61-90 days		0	3	0
	# Remediated	22	25	15
	% Remediated	100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of investigations completed by AEs to determine if ODP investigation standards were met. If ODP expectations were not met, AEs will initiate remediation which may include counseling and/or retraining of certified investigators. Documentation of remediation actions must be submitted to ODP within 30 days. As part of the investigation, an investigator must take their first witness statement within 24 hours of being assigned an investigation. The investigator must also complete all witness interviews within 10 days of being assigned the investigation. The investigation and a final investigation determination (either confirmed or not confirmed) must be completed within 30-days.

Agency Follow up and Improvement: During SFY 14/15, ODP clarified the application of guidelines for review of this measure. Through analysis, ODP recognizes the need to establish criteria to allow for extenuating circumstances and/or offer opportunity for exception to timeframes in cases such as states of emergency or circumstances beyond the control of the investigator.

Through annual review and analysis of the AE Oversight Monitoring Process and data results by region, ODP recognized the need to allow for extenuating circumstances and/or offer opportunity for exception to timeframes in cases such as states of emergency or circumstances beyond the control of the investigator. ODP is clarifying the monitoring guidelines and retraining expectations.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance with Performance Measure HW.a.i.4

Table 5.5 Performance Measure HW.a.i.5.

Performance Measure: Number and percent of critical incidents, confirmed, by type. (Data Source: HCSIS) **Numerator (N):** Number of Incidents of Abuse, Neglect, Rights Violations, Misuse of Funds, or Death in Provider Operated Setting, respectively **Denominator (D):** All critical incidents, confirmed		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
	Total Number of Critical Incidents, Confirmed **(D)**	3,124	3,347	3,235
Abuse	(N/D) %	861/3,124 27.5%	884/3,347 26.4%	785/3,235 24.2%
Neglect	(N/D) %	1477/3,124 47.2%	1732/3,347 51.7%	1778/3,235 54.9%
Rights Violation (exploitation)	(N/D) %	240/3,124 7.6%	398/3,347 11.8%	357/3,235 11%
Misuse of Funds (exploitation)	(N/D) %	435/3,124 13.9%	211/3,347 6.3%	228/3,235 7%
Death in Provider Operated Setting	(N/D) %	111/3,124 3.6%	122/3,347 3.6%	87/3,235 2.6%

Details: This performance measure is designed to support evaluation of trends and patterns in the occurrence of critical incidents. The number and percent of critical incidents, confirmed, by type is reviewed to identify opportunities for systemic improvement. The denominator reported for this measure represents the total number of critical incidents, confirmed, by type, per state fiscal year. This measure is a subset of HWai3 and focuses only on confirmed critical incidents (incidents of abuse, neglect, exploitation and death).
In addition to the Child Protective Services Law and the Older Adult Protective Services Act, the implementation of the Adult Protective Services Act in July 2014 has established mandatory reporting requirements for Community members (doctors, nurse, EMTs, teachers, bus drivers, etc.) to report suspected abuse, neglect (including abandonment) and exploitation of individuals between the ages of 18 to 59 with an intellectual disability that they see in the community. Since that time, neglect allegations have increased; however, the percent of critical incidents that are confirmed remains consistent with prior years.

Agency Follow up and Improvement: ODP continues to encourage reporting of critical incidents. The number and percent of critical incidents confirmed, by type are reviewed to identify opportunities for systemic improvement. With each critical incident confirmed a corrective action is carried out or planned by the appropriate entity. ODP continues to develop incident management and risk mitigation trainings for all stakeholders and provide targeted technical assistance as needed.

Enhancements were made to the ODP Certified Investigation course. Specifically, the state strengthened the training content related to conducting a preponderance of evidence standard and clarified the definitions of "confirmed, not confirmed, and inconclusive". In addition, the state continues to enhance the course with best practices. ODP provided education about recognition and reporting to all AEs, supports coordination organizations and providers. In conjunction with the Division of Adult Protective Services, mandatory reporting training was developed and issued to all AEs, supports coordination organizations and providers.

ODP developed and released a series of trainings specific to "Identifying and Mitigating Risk". These trainings are available to all stakeholders including AEs, supports coordination organizations, provider agency staff, and individuals and families. These trainings focus on practices to help teams assess potential risks, develop and implement risk mitigation strategies, evaluate strategies for effectiveness and success, recognize progress and assess again, and identify if additional strategies are warranted.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.5 has been met.

Table 5.6 Performance Measure HW.a.i.6.

Performance Measure: Number and percent of critical incidents, confirmed, where corrective actions were carried out or planned by the appropriate entity within the required time frame. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13-14**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of critical incidents, confirmed, where corrective actions were carried out by the appropriate entity within the requiredtimeframe.* ***Denominator =*** *Number of critical incidents, confirmed, where corrective actions were required.*	N	3,116	3,339	3,231
	D	3,124	3,347	3,235
	% (N/D)	99%	99%	99%
REMEDIATION DATA				
	Noncompliant	8	8	4
Clarifying Detail Regarding Corrective Action(s) Added to Report		4	4	3
Additional Corrective Action(s) Added to Report		4	4	1
Remediated within 30 days		4	1	4
Remediated within 31-60 days		3	4	0
Remediated within 61-90 days		1	0	0
	# Remediated	8	8	4
	% Remediated	100%	100%	100%

Details: The AE and ODP review confirmed critical incidents to ensure that corrective actions resulting from certified investigation are carried out or planned by the appropriate entity within the required timeframe. If corrective actions are not carried out or planned by the appropriate entity within the required time frame, the AE or ODP will follow up to ensure the corrective actions are carried out or planned within 10 days. All remediation steps are entered into the incident report and are subject to final approval by ODP.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.6 has been met.

Table 5.7 Performance Measure HW.a.i.7.

Performance Measure: Number and percent of waiver participants who receivedinformation about reporting abuse, neglect, and exploitation. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants who received informationabout reporting abuse, neglect, and exploitation.* ***Denominator =*** *Number of waiver participants in the sample.*	N	7	279	303
	D	7	313	315
	% (N/D)	100%	89%	96%
REMEDIATION DATA				
Number noncompliant		0	34	12
Documentation was located		0	18	6
ISP Signature Page was completed		0	7	6
SCs completed training		0	9	0
Remediated within 30 days		0	3	2
Remediated within 31-60 days		0	21	8
Remediated within 61-90 days		0	1	2
Remediated in >90 days		0	9	0
# Remediated		0	34	12
% Remediated		N/A	100%	100%

Details: Through the AEOMP, ODP reviews a sample of records to determine if participants/ families have been provided information about reporting abuse, neglect and exploitation. If there was no documentation that the information was provided, the AE will work with the SCO to provide the information to the participant/family and complete the required documentation on the ISP Signature Page. In some cases where the information was provided but not documented, the ISP Signature Page is updated. The SC will meet with the individual and/or family to provide information about reporting abuse, neglect, and exploitation. The ISP signature page will be updated to reflect the date the information was reviewed. The AE is expected to document the remediation actions and submit the documentation to ODP within 30 days.

During SFY 12/13, ODP updated the ISP signature page (checklist) to include a question to validate the individual was provided information about reporting abuse, neglect and exploitation. Use of the ISP signature page was initiated during SFY 12/13 but not fully implemented that year, explaining the increase in reporting from SFY 12/13 to SFY 13/14 and forward.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.7 has been met.

Table 5.8 Performance Measure HW.a.i.8.

Performance Measure: Number and percent of AEs that maintain documentation ofincident management training. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of AEs that maintain documentation of incident management training.* ***Denominator =*** *Number of AEs.*	N	44	47	44
	D	48	48	48
	% (N/D)	92%	98%	92%
REMEDIATION DATA				
Noncompliant		4	1	4
Documentation is located verifying that IM training has beendone		1	0	0
Documentation that training has been completed is provided		3	1	4
Remediated within 30 days		4	0	4
Remediated within 61-90 days		0	1	0
# Remediated		4	1	4
% Remediated		100%	100%	100%

<u>Details</u>: Through the AEOMP, ODP reviews AEs to determine if incident management training has occurred. When documentation of Incident Management training cannot be produced, AEs must complete the training and/or provide documentation that training has occurred and implement a Corrective Action Plan to prevent future noncompliance. AEs are expected to document the remediation actions and submit the documentation to ODP within 30 days.

<u>CMS Findings and Recommendations:</u>

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.8 has been met.

Table 5.9 Performance Measure HW.a.i.9.

Performance Measure: Number and percent waiver participants for whom there wasan unreported critical incident, by type. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of waiver participants for whom there was an unreported critical incidents, by type of incident.* ***Denominator =*** *Number of waiver participants in the sample.*	N	6	8	12
	D	314	317	318
	% (N/D)	1.9%	2.5%	3.8%
REMEDIATION DATA				
Noncompliant		14	13	22
Number of critical incidents of abuse that were not reported		5	4	9
Number of critical incidents of neglect that were not reported		5	7	5
Number of critical incidents of exploitation that were not reported		4	0	7
Number of other critical incidents that were not reported		0	2	1
Unreported critical incidents filed in HCSIS within 24 hours of notification		14	13	22
# Remediated		14	13	22
% Remediated		100%	100%	100%

Details: Through the AEOMP, ODP reviews a sample of participant records to ensure that critical incidents are reported. If it is determined that a critical incident was not reported, ODP will notify the AE immediately. The AE will instruct the provider to enter the information into HCSIS, work with the provider to ensure that action has been undertaken to protect the participant's health, safety and rights and will submit notification to ODP documenting what remediation actions occurred within 24 hours.

The number of unreported incidents is greater than the number of participants with unreported incidents which aligns with the measure; however, in order to ensure the health and safety of all participants, remediation serves to ensure that all identified unreported incidents are filed.

ODP follows the standard incident management process when the unreported critical incident is discovered. This includes follow-up with the participant/family regarding notification of the incident, the outcome of the investigation, and the implementation of all necessary corrective actions. ODP validates remediation through the AEOMP Corrective Action Plan (CAP) process. Remediation strategies include:

- the unreported critical incident is filed in HCSIS within 24 hours.
- the unreported critical incident is remediated through the incident management process.
- the unreported critical incident is referred to appropriate staff for follow-up.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.9 has been met.

Table 5.10 Performance Measure HW.a.i.10.

Performance Measure: Number and percent of deaths, by cause of death. (Data Source: Mortality Review Database)			**CY 2012**	**CY 2013**	**CY 2014**
DISCOVERY DATA					
Numerator (N) *= Number of deaths, by cause of death.* ***Denominator (D)*** *= All deaths.* ***% = (N)/(D)***		Total Deaths **(D)**	264	271	275
BY TYPE					

	2012 (N)/(D) %		**2013 (N)/(D) %**		**2014 (N)/(D) %**
Heart Disease	58/264 22%	Diseases of Heart	67/271 24.7%	Diseases of Heart	64/275 23.3%
Dementia (including Parkinson's)	45/264 17%	Cancer	25/271 9.2%	Pneumonia, aspiration	23/275 8.4%
Cancer	29/264 11%	Pneumonia, aspiration	20/271 7.4%	Cancer	19/275 6.9%
Pneumonia	23/264 8.7%	Pneumonia	18/27 6.6%1	Pneumonia	19/275 6.9%
Diseases of the lower respiratory tract	15/264 5.7%	Sepsis	14/271 5.2%	Seizure Disorder	9/275 3.3%
Seizure	12/264 4.5%	Diseases of the nervous System	11/271 4.1%	Sepsis	9/275 3.3%
Sepsis	11/264 4.2%	Asphyxiation	10/271 3.7%	Cerebrovascular accident	7/275 2.5%
Diseases of the digestive system	10/264 3.8%	Seizure Disorder	7/271 2.6%	Gastrointestinal	6/275 2.2%
Congenital	9/264 3.4%	Dementia	6/271 2.2%	Diseases of the nervous System	6/275 2.2%
Asphyxia (choking)	8/264 3%	Gastrointestinal	6/271 2.2%	Dementia	4/275 1.5%
Diseases of the vessels (stroke)	7/264 2.7%	Disease of the Respiratory system	5/271 1.8%	Dementia, Alzheimer	4/275 1.5%
Aspiration pneumonia	5/264 1.9%	Aspiration	4/271 1.5%	Disease of the Respiratory system	4/275 1.5%
Renal	4/264 1.5%	Cerebrovascular accident	4/271 1.5%	ACCIDENTAL	3/275 1.1%
Pulmonary embolus	4/264 2.5%	Inanition (Adult Failure To Thrive)	4/271 1.5%	Aspiration	3/275 1.1%
Fall	3/264 1.1%	Unknown	4/271 1.5%	Inanition (Adult Failure To Thrive)	3/275 1.1%
Inanition (adult failure to thrive)	3/264 1.1%	Dementia, Alzheimer	2/271 .7%	Asphyxiation	2/275 .7%
Hemorrhage	2/264 .8%	Sudden Death	2/271 .7%	Cirrhosis	2/275 .7%
Liver Disease	2/264 .8%	Musculoskeletal	1/271 .4%	Diabetes	2/27 .7%
Anaphylaxis	1/264 .4%	Indeterminate	18/271 6.6%	Congenital Hydrocephalous	1/275 .4%
Asthma	1/264 .4%	Blank	43/271 15.9%	Decubiti	1/275 .4%
Car accident	1/264 .4%			Hypoxemia	1/275 .4%
Diabetes	1/264 .4%			Kidney Disease	1/275 .4%
Hydrocephalous	1/264 .4%			Musculoskeletal	1/275 .4%
Myasthenia Gravis	1/264 .4%			Parkinson's	1/275 .4%
Myotonic Dystrophy	1/264 .4%			Shunt Failure	1/275 .4%
Pancreatitis	1/264			Spina bifida	1/275

	.4%				.4%
Thrombocytopenic Thrombotic Purpura (TTP)	1/264 .4%			Unknown	1/275 .4%
Unknown	1/264 .4%			Indeterminate	30/275 10.9%
				Blank	47/275 17.1%

<u>Details</u>: This performance measure is designed to support evaluation of trends and patterns in the occurrence of deaths. The number and percent of deaths is reviewed to identify opportunities for systemic improvement. The denominator reported for this measure represents the total number of deaths per calendar year.

The causes of death are presented in order to examine findings within the context of CDC National Center for Health Statistics (NCHS) for both the US and PA. The top causes of death are fairly stable across the last three years in terms of numbers and percentage of cause of death – diseases of the heart, cancer, aspiration/pneumonia, and pneumonia. Diseases of the heart include cases where cause of death (COD) on death certificate was *Cardiac Arrest* and where no additional information was available to further clarify the COD. The incidence of most other causes of death is too small to analyze. For CY 2012, comparing ODP mortality findings with the most recent available leading causes of death for the general population (CDC, 2009), dementia and gastrointestinal disorders continue to represent a larger proportion of the causes of death in the Consolidated Waiver population than the general population. While dementia may occur at a higher incidence in certain subpopulations of persons with IDD, there may also be a reporting bias to identify individuals with intellectual disability as having dementia as compared to the general population. Diseases of the heart include cases where COD on death certificate was *Cardiac Arrest* and where no additional information was available to further clarify the COD.

ODP, consistent with general public health practices, utilizes findings to plan health related remediation, health prevention/management and health education/promotion activities designed to help people to live longer and healthier lives as well as improve quality of life overall. However, before such activities can be designed and implemented, data integrity and validity need to be improved.

ODP experienced challenges during this Waiver cycle in designating causes of death as death certificates are not always available and information in the death certificate is not always reliable. Additionally, the mortality review process is time consuming and manual. Further, because some of the COD counts are small, it is difficult to determine to what extent this information is reflective of the causes of death for the PA I/DD population in general.

<u>Agency Follow up and Improvement</u>: ODP will examine the mortality review process and identify strategies to streamline review that include best practices and are standardized, user- friendly, and support reliable and valid analysis as well as prevention and promotion efforts. ODP will communicate with appropriate medical authorities to provide outreach education regarding the need to correctly complete death certificates by following the CDC Instructions for Completing the Cause-of-Death Section of the Death Certificate (CDC

publication) and the PA DOH Bureau of Health Statistics Research 2012 Death Certificate Registration Manual.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.10 has been met.

Table 5.11 Performance Measure HW.a.i.11.

Performance Measure: Number and percent of deaths of waiver participants examined according to State protocols. (Data Source: Mortality Review Database)		**CY 2012**	**CY 2013**	**CY 2014**
DISCOVERY DATA				
Numerator (N) = *Number of deaths of waiver participants examined according to State protocols.*	N	25	57	47
Denominator = *Number of deaths of waiver participants requiring examination according to State protocols.*	D	25	57	47
	% (N/D)	100%	100%	100%

Details: When ODP discovers that a Waiver participant whose death occurred in a residential setting was not examined according to the state's protocol, ODP follows up with the appropriate entity to ensure the required protocol is carried out within 24 hours and a Corrective Action Plan is developed and implemented to prevent recurrence.

State protocol requires that such agencies contact the coroner when someone who is not receiving hospice services because of a terminal illness dies in their residence. The coroner was called for all of the 25 Waiver participants during calendar year 2012 that were not receiving Hospice services and died in their residence.

Additional focus was expanded to consumers who were residing in a provider operated setting at the time of their death and who were not receiving hospice services at the time, as per state protocol, their deaths were to be reported to the Coroner's office. Providers met this requirement by contacting the coroner at the time of death for all consumers who met these criteria during CY2013 and CY 2014.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.11 has been met.

Table 5.12 Performance Measure HW.a.i.12.

Performance Measure: Number and percent of incidents of restraint where proper procedures were followed, by type of restraint. (Data Source:HCSIS)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of incidents of restraint where proper procedures were followed, by type of restraint.* ***Denominator =*** *Number of incidents of restraint, by type of restraint.*	N	2,404	3,390	2,948
	D	2,408	3,396	2,952
	% (N/D)	99%	98%	99%
REMEDIATION DATA				
Number noncompliant		4	6	4
Staff Retrained on policy		4	6	4
Remediated within 30 days		4	6	4
# Remediated		4	6	4
% Remediated		100%	100%	100%

Details: ODP regulations specify that any Waiver participant who has two emergency restraints within a six month period must have a behavior support plan with a restrictive procedure plan. When ODP discovers that proper procedures were not followed, a behavior support plan with a restrictive procedure plan that meets ODP regulations must be developed, approved and implemented within 30 days.

ODP regional risk managers monitor the type of restraint to ensure that whenever possible, restraints are part of an approved behavior support plan. 93% of all reported restraints were part of an approved plan. Of the emergency restraints which occurred, 99% were physical restraints in 99% of restraints administered. Through the dual diagnosis initiative leads, ODP focuses technical support on assisting providers to apply restraint reduction techniques for participants who experience multiple restraints to better manage risks associated with restrictive interventions.

When a restraint is used, the event is reported as required by ODP's incident management process. This process includes notification to the participant/ family that a restraint occurred. In addition, a debriefing with the participant's team occurs following the use of the restraint to discuss potential antecedents, any least restrictive interventions utilized prior to the application of the restraint, and any updates needed to existing behavior support plans. All updates are based on team meetings which include the participant/family. A copy of the revised plan is provided to the participant/family.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.12 has been met.

Table 5.13 Performance Measure HW.a.i.13.

Performance Measure: Number and percent of medication errors, by type. (Data Source: HCSIS)		**SFY 12-13**	**SFY 13**	**FY 4-15**
DISCOVERY DATA				
Numerator (N) = *Number of medication errors, bytype.* ***Denominator (D) =*** *All medication errors.* ***%=(N)/(D)***	Total Medication Errors **(D)**	9,(	9,	8,869
BY TYPE				
Omission	(N/D) %	6172/9063 68.1%	6651/9877 67.4%	6073/10885 68.5%
Wrong Dose	(N/D) %	1278/9063 14.1%	1457/9877 14.8%	1251/10885 14.1%
Wrong Form	(N/D) %	2/9063 (02%	2/9877 0.0%	4/10885 0.0%
Wrong Medication – extra dose	(N/D) %	298/9063 3.3%	311/9877 3.2%	252/10885 2.8%
Wrong Medication - discontinued	(N/D) %	158/9063 1.7%	190/9877 1.9%	213/10885 2.4%
Wrong Medication – for another reason	(N/D) %	59/9063 0.7%	44/9877 0.4%	34/10885 0.4%
Wrong Person	(N/D) %	239/9063 2.6%	250/9877 2.5%	222/10885 2.5%
Wrong Position	(N/D) %	0/9063 0%	0/9877 0%	1/10885 0.0%
Wrong Route	(N/D) %	4/9063 (03%	7/9877 0.1%	8/10885 0.1%
Wrong Technique or Method	(N/D) %	13/9063 0.1%	26/9877 0.3%	16/10885 0.2%
Wrong Time	(N/D) %	832/9063 9.3%	930/9877 9.4%	795/10885 9.0%

Details: This performance measure is designed to support evaluation of trends and patterns in the occurrence of medication errors. The number and percent of medication errors is reviewed to identify opportunities for systemic improvement. The denominator reported for this measure represents the total number of medication errors per fiscal year. The average number of remediation activities per medication error/fiscal year was 1.89 for FY 14-15.

There were an additional 15,384 actions taken by the agency to prevent recurrence. The most common types of errors in order of decreasing frequency are omission, wrong dose and wrong time. The most frequently utilized remediation actions included contacting the program supervisor, contacting health care professional, and observing for side effects. The most frequently utilized prevention actions were: providing feedback to the individual employee and providing training and/or retraining.

The increases noted in both the count of medication errors and remediation and prevention activities are attributed to the addition of new information about medication administration best practices integrated into the medication administration training.

Awareness of what constitutes a medication error and the recognition of medication errors result in better reporting. It is not unusual to see increases in the count of medication errors or better reporting following training events.

Agency Follow up and Improvement: ODP will continue to monitor patterns and trends in analysis of types of medication errors, cause, remediation and preventive actions to identify improvement opportunities. ODP will evaluate new information about medication administration best practices to incorporate into both the initial course and on-going medication administration monitoring. ODP will evaluate new information about medication errors to determine causes and contributing factors to develop additional remediation and teaching strategies and continue to update all trainers with findings and recent developments in medication administration best practices.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.13 has been met.

Table 5.14 Performance Measure HW.a.i.14.

Performance Measure: Number and percent of complaints, by type. (Data Source: Compliant Log)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of complaints, by type.* ***Denominator =*** *All complaints.*	N	76	111	102
BY TYPE				
Abuse of Individual		1/1%	15/13%	8/8%
Administrative Entity		4/5%	8/7%	8/8%
Civil Rights of Individual		0/0%	1/1%	0/0%
Direct Support Staff		11/14%	7/5%	21/22%
Exploitation of Individual		1/1%	3/3%	0/0%
HCBS Waiver		1/1%	1/1%	1/1%
Neglect of Individual		0/0%	3/3%	1/1%
Office of Developmental Programs		6/8%	8/7%	4/4%
Other		5/7%	8/7%	6/7%
Provider Agency		43/57%	50/46%	43/41%
Supports Coordination Organization		4/5%	5/5%	8/8%
Unspecified		0/0%	0/0%	1/1%
Violation of Individual Rights		0/0%	2/2%	1/1%

Details: For purpose of this measure, the Department applies the CMS technical guide definition of "complaint," which is "the formal expression of dissatisfaction by a participant with the provision of a Waiver service or the performance of an entity in conducting other activities associated with the operation of a Waiver." Complaints may be received from program participants, family members and representatives, AEs, providers, advocates, and other interested parties through a centralized customer service line. This performance measure is designed to support evaluation of trends and patterns in the occurrence of complaints. The

number and percent of complaints is reviewed to identify opportunities for systemic improvement. The complaint types shown reflect the type of allegation or the entity against which the complaint is directed.

Upon receipt of a complaint, regional office staff contacts the complainant to acknowledge receipt of the complaint and to collect additional information, unless the complainant is anonymous or did not provide contact information. When comprehensive intake information is received, regional office staff determines whether the complaint should be investigated by ODP or an entity subject to ODP's direct authority (i.e. an administrative entity, supports coordination organization, or provider), or if the complaint should be referred to an external oversight entity, e.g. the Bureau of Human Services Licensing, the Pennsylvania Department of Health, Pennsylvania Adult Protective Services, law enforcement, etc.

In cases where the complaint is investigated by ODP or its subordinate entities, regional office staff provides direction and information to the investigating entity and recommends they follow up with the reporting participant/family. In some cases, depending on the nature of the complaint, the regional office staff follows up with the person reporting to provide the investigation results and/or ensure resolution fully addressed the concerns. In cases where the complaint is referred to an external oversight entity, ODP notifies the complainant that the referral has been made, and that the external entity will notify the complainant of the investigation results in accordance with the entity's policy on follow-up to complainants. Additionally, complainants can and do contact the ODP Customer Service Line to inquire about the status of an investigation. Calls of this type are referred to the investigating region for appropriate response.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.14 has been met.

Table 5.15 Performance Measure HW.a.i.15.

Performance Measure: Number and percent of complaints resolved within 21 days of receipt. (Data Source: Compliant Log)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of complaints resolved within 21 days ofreceipt.*	N	38	54	95
Denominator = *Number of complaints received.*	D	76	111	102
	% (N/D)	50%	49%	93%
REMEDIATION DATA				
Number noncompliant		38	57	7
Remediated within 30 days		0	8	2
Remediated within 31-60 days		0	4	2
Remediated within 61-90 days		0	0	2
Remediated in >90 days		0	1	1
Resolution date not recorded		38	44	0
Remediated		38	57	7
% Remediated		100%	100%	100%

Details: All complaints were resolved; however, resolution dates were not captured in the log for FY 12-13 and portions of FY 13-14. This identified problem was corrected in FY 14-15.

Agency Follow up and Improvement: The Department is reviewing its complaint intake and response documentation procedures to improve reliability and consistency in measurement in SFY 15-16. Planned objectives include updating the procedures and tools used in the administration of the customer service line. Some complaints could only be resolved via the Department's investigative procedures, which allow for investigation timeframes longer than 21 days. Allowances for extensions in complex cases, and adherence to documentation standards are slated to be addressed in the Department's revised complaint procedures.

The Department is reviewing its complaint intake and response documentation procedures to improve reliability and consistency in measurement in SFY 15-16. Planned objectives include updating the procedures and tools used in the administration of the customer service line. The action plan to achieve this outcome includes the following steps:

- Amending the current Customer Service Line (CSL) Protocol to outline various inquiry types, one of which is Complaints; provide a list of complaint types with definitions, e.g. Dissatisfaction with Administrative Entity, Dissatisfaction with Provider's Performance, Dissatisfaction with Supports Coordination Organization, Dissatisfaction with Waiver Program, Mistreatment of Individual etc.
- Establishing a CSL Protocol that defines how to triage all inquiries to the appropriate source for resolution, e.g. issues already being managed through the Department's Incident Management process.
- Developing documentation standards.
- Establishing a CSL Protocol for the routine monitoring of inquiries to ensure timely resolution.
- Establishing a CSL Protocol that defines when an inquiry is considered closed, and what circumstances, if any, warrant an extension beyond 21 days for resolution to occur (e.g., a person who must be interviewed as part of an investigation is out of the country for an extended period of time).
- Identifying a reliable CSL data system to ensure that all relevant data is captured and reported accurately and timely, and to specifically identify complaints within the larger context of all customer service inquiries.

Revising and reissuing the Customer Service Line Protocol to include, at a minimum:

- Definition of various types of inquiries expected through the CSL and triage of each
- Updated CSL Protocols\Directions for using the new data system described above
- Documentation standards and expectations.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.15 has been met.

Table 5.16 Performance Measure HW.a.i.16.

Performance Measure: Number and percent of providers that ensure waiver participants receive physical exams in accordance with ODP rules. (Data Source: Licensing Data)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of providers that ensure waiver participants receive physical exams in accordance with ODP rules.* ***Denominator =*** *Number of providers reviewed.*	N	812	217	226
	D	854	269	259
	% (N/D)	95%	81%	87%
Number of physical exams completed late		N/A	22	33
Within 30 days		N/A	10	14
Within 31 – 60 days		N/A	4	9
Within 61 – 90 days		N/A	5	2
In greater than 90 days		N/A	3	8
Number compliant before remediation		N/A	237	259
% compliant before remediation		N/A	88%	100%
REMEDIATION DATA				
Noncompliant requiring remediation		42	30	0
Missing documentation of physical exam located		31	10	0
Physical exam completed and documentation submitted		11	20	0
Remediated within 30 days		18	13	0
Remediated within 31-60 days		13	9	0
Remediated within 61-90 days		4	3	0
Remediated in >90 days		7	5	0
# Remediated		42	30	0
% Remediated		100%	100%	N/A

Details: In July 2012, the Department consolidated all licensing responsibilities under the Bureau of Human Services Licensing (BHSL). As such, oversight of this performance measure is a collaborative effort between BHSL and ODP. BHSL implemented a new enterprise-wide licensing system known as the Certification and Licensing System (CLS) during SFY 13/14. Data in 12/13 and 13/14 reflect a duplicated count of providers if multiple services were provided within a single agency. The identification of providers in CLS is now unduplicated and according to Master Provider Identifier (MPI).

The Department conducts annual onsite reviews of licensed providers. The Department notes any regulatory violations, including a provider's failure to meet the requirement for Waiver participants to receive annual physical examinations, and documents the findings on a Licensing Inspection Summary (LIS). The LIS is submitted to the provider who must return the document to the

Department within 10 calendar days of the date of transmission from the Department. Providers must specify how the noncompliance has been corrected or will be corrected.

The Department will verify that correction has been made through documentation produced by the provider showing evidence that the physical exam occurred and the date it occurred. The provider must correct the identified violation no more than 90 days from the date the LIS was mailed to the provider.

CMS Findings and Recommendations:

Evidence provided by the State demonstrates compliance of Performance Measure HW a.i.16 has been met. Overall, documentation provided by the State demonstrates compliance with the Health and Welfare assurance.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Authority: 42 C'FR 441.303; 42 CFR 431• SMM 4442.6; SMM 4442.7

The state substantially meets the assurance.

Table 1.1 Performance Measure AA.a.i.1.

Performance Measure: Number and percent of AEs that implement monitoring protocols using the ODP standardized monitoring tool. (Data Source: AEOMP)		**SFY 12-**	**SFY 13-**	**SFY 14-**
DISCOVERY DATA				
Numerator (N) *= Number of AEs that implement monitoring protocols using the ODP standardized monitoring tool.* ***Denominator (D)*** *= Number of AEs that delegate or purchase administrative functions.*	N	19	21	27
	D	24	29	31
	% (N/D)	79%	72%	87%
REMEDIATION DATA				
	Noncompliant	5	8	4
AE implemented monitoring protocols		4	3	3
AE located documentation to substantiated protocols were implemented		1	5	1
Remediated within 30 days		4	7	3
Remediated within 31-60 days		1	0	1
Remediated within 61-90 days		0	1	0
Remediated in >90 days		0	0	0
	# Remediated	5	8	4
	% of AEs remediated	100%	100%	100%

Details: The AE Operating Agreement establishes the roles and responsibilities of AEs with respect to functions delegated to them for program administration. There are a total of 48 AEs; however, not all 48 AEs delegate or purchase administrative functions therefore causing the variance of AEs in the denominator per SFY.

AEs may delegate and purchase administrative functions in accordance with the AE Operating Agreement. When AEs delegate or purchase administrative functions, they shall retain responsibility for compliance with the AE Operating Agreement. In addition, AEs are responsible to monitor delegated or purchased administrative functions to ensure compliance with applicable Departmental rules, Waiver requirements, written policies and procedures, and state and federal laws.

ODP receives from each AE annually a list of administrative functions that are delegated or purchased by that AE along with a copy of the monitoring protocol for each delegated or purchased function. On an annual basis, ODP reviews the list of each AE's delegated or purchased functions to verify implementation of the monitoring protocol.

If ODP determines that an AE is not implementing monitoring activities as required by the protocol, the AE will be notified and is expected to complete remediation within 30 days. Remediation can be completed by the AE locating missing evidence that documents their implementation of the monitoring protocol and/or by the AE implementing required monitoring protocols and providing ODP supporting evidence. Evidence may include but is not limited to AE correspondence with the entity that carries out the delegated and/or purchased function containing findings of monitoring, records of on-site visits to the entity or entities involved, and corrective actions taken by the entity or entities involved.

Agency Follow-Up and Improvement: Performance of the AEs demonstrates improvement over time and can be attributed to training and targeted technical assistance provided by ODP regional staff in the areas of non-compliance.

CMS Findings and Recommendations:
Evidence provided by the State demonstrates compliance of Performance Measure AA.a.i.1 has been met.

and resubmit in order to obtain the increased rate.

Table 6.4 Performance Measure FA.a.i.4.

Performance Measure: Number and percent of providers whose claims are supported by documentation that services were delivered. (Data Source: Provider Monitoring)		**SFY 12-**	**SFY 13-**	**SFY 14-15**
DISCOVERY DATA				
Numerator (N) = *Number of providers whose claims are supported by documentation that services were delivered.* ***Denominator =*** *Number of providers reviewed.*	N	195	218	246
	D	237	269	301
	% (N/D)	81%	81%	82%
REMEDIATION DATA				
Noncompliant		42	51	55
Missing documentation was located		5	7	4
Remittance of corrected billing		21	35	48
Staff Training		5	4	1
Revision of policy/procedures		3	3	1
Termination of Provider Agreement		2	0	0
Billing suspended pending investigation of fraud by Attorney General		1	0	0
Referral to BPI		1	0	0
Provider withdrew		2	2	1
Within 30 days		24	32	31
Within 60 days		5	11	13
Within 90 days		6	6	6
Beyond 90 days		7	2	5
# Remediated		42	51	55
% Remediated		100%	100%	100%

Details: In addition to the set of comprehensive edits and audits incorporated into the State's CMS certified Medicaid Management Information System (MMIS), PROMISe™, ODP has outlined a Provider Monitoring process which includes On-Site Review of providers by AEs. AEs review 50% of providers annually so that over a two-year cycle, 100% of providers are reviewed on-site. The monitoring tool contains a question in reference to documentation to support claims for services. A single instance of noncompliance results in a "finding". If a provider did not have authorized services during the prior fiscal year, the provider would not have paid claims for that year and would not have claims to review. Therefore, the question regarding documentation to support claims for services is not applicable.

Agency Follow up and Improvement: ODP has focused efforts on refining the monitoring process and clarifying claim documentation expectations to stakeholders which includes a Progress Note template which has been approved for use as a resource document. ODP has communicated via Informational Packet #035-14, issued 6/13/14 "Waiver Service Claim Documentation and Remediation Process" which addresses actions that should be taken when issues arise with Waiver claims submission or supporting documentation. This communication also describes the process

to follow if the reviewer is concerned that the findings during an on-site review may be the result of fraud. This includes referrals to the Bureau of Program Integrity.

ODP has communicated via Informational Packet #062-15, issued 7/31/15, “Enforcement Actions against Noncompliant ODP Intellectual Disability Waiver Providers” what sanctions may be taken based on ODP's authority in the 55 Pa. Code Chapter 51 regulations and has established a sanction policy to articulate the actions that could be taken in the event of repeat non-compliance. These actions include withholding, disallowing, suspending or recouping payment or future payment, disallowance of new service locations, services or new individuals.

CMS Findings and Recommendations

Evidence provided by the state demonstrates that the assurance has been met. Documentation submitted by Commonwealth of Pennsylvania indicates appropriate systems in place to ensure that there is an adequate system for assuring financial accountability.